





# EYE SPECIALISTS

OF LOUISIANA

## MEDICAL INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Do you have, or have you ever had:

YES	NO		YES	NO	
_____	_____	Hypertension (High Blood Pressure)	_____	_____	HIV Positive
_____	_____	Diabetes	_____	_____	Glaucoma
_____	_____	Thyroid Disease	_____	_____	Blindness in either eye
_____	_____	Kidney Disease	_____	_____	Tuberculosis
_____	_____	Stroke	_____	_____	Cancer
_____	_____	Color Blindness	_____	_____	Macular Degeneration
_____	_____	"Lazy" Eye	_____	_____	Multiple Sclerosis
_____	_____	Rosacea	_____	_____	Shingles

Any other medical dx not listed (ex: Auto Immune) \_\_\_\_\_

Do you have any drug allergies? If yes, please list:

\_\_\_\_\_

Are you currently taking any medications? If yes, please list:

\_\_\_\_\_

Are you currently experiencing any of the following problems?	YES	NO
- Recent changes in your vision	_____	_____
- Vision is sometimes blurry	_____	_____
- Itchy eyes	_____	_____
- Burning sensation in your eyes	_____	_____
- Pain in your eyes	_____	_____
- Frequent headaches or eyestrain	_____	_____
- Twitches or tics around your eyes	_____	_____
- Light flashes, floaters, or shadows	_____	_____
- Eye redness, swelling, puffiness, bloodshot, etc.	_____	_____

If you checked yes to any of the above questions, please provide details:

\_\_\_\_\_

Have you ever had any eye surgery, including LASIK or laser procedures? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, what kind? \_\_\_\_\_

Have you ever had an eye injury? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, what happened? \_\_\_\_\_

Do you use:  
Cigarettes/Tobacco: YES \_\_\_\_\_ NO \_\_\_\_\_ Alcohol: YES \_\_\_\_\_ NO \_\_\_\_\_ Other drugs: YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have any family history (blood relative) of:  
\_\_\_\_\_ Glaucoma \_\_\_\_\_ Cataracts \_\_\_\_\_ Macular Degeneration \_\_\_\_\_ Blindness  
Other eye problems \_\_\_\_\_

Is there anything else you would like to discuss with the doctor?

\_\_\_\_\_



# EYE SPECIALISTS OF LOUISIANA

David M. Dragon, M.D. • Tim D. Johnson, M.D.  
Thomas C. Stuckey III, M.D. • Lillian M. Forstall, O.D.

## OFFICE POLICIES

**By Federal and Managed Care Contract Law this practice is required to collect co-payments and deductibles for every encounter.** Penalty for not doing so could result in termination of insurance coverage, as we are required to notify your insurance carrier of failure to pay at time of services rendered.

Statements are mailed every thirty (30) days for any outstanding balances that remain after your insurance company has processed a claim. Balances must be paid in full within thirty (30) days of the statement date unless the business office has approved payment arrangements. Failure to make payments in a timely manner will result in your account being placed with a collection agency.

**It is the policy of this office to make a copy of your driver's license to prevent identify theft.** This action allows us to verify that your signature matches the one on our sign-in sheets and any other forms that require a signature.

---

Signature of Patient/Guardian

---

Date

---

Relationship of signing party to patient



# EYE SPECIALISTS OF LOUISIANA

## NON-COVERED SERVICES

Dear Patient:

Medicare regulations require that in order to collect payment, you must be informed in advance that a service may not be covered by your insurance plan. This does not imply that the services recommended by your physician are not medically necessary.

Many insurance companies, as well as Medicare and Medicaid, do not pay for the refraction portion of an eye exam nor for some diagnostic tests, including but not limited to A-Scans and Optic Nerve Tomography.

---

### Beneficiary Agreement

I have been notified by Eye Specialists of Louisiana that reimbursement for certain services and/or procedures may be denied by my health insurance coverage and I agree to be personally and fully responsible for payment of same.

---

Patient's Signature

---

Date

David M. Dragon, M.D.  
*Board Certified Ophthalmologist*

Tim D. Johnson, M.D.  
*Board Certified Ophthalmologist*

Thomas C. Stuckey III, M.D.  
*Board Certified Ophthalmologist*

Lillian M. Forstall, O.D.  
*Optometrist*

## **ROUTINE EXAM VS. MEDICAL EXAM, REFRACTION**

Your symptoms/visual complaints, or lack of, will determine if your vision exam is coded as “Routine” or “Medical”. The decision to file as routine or medical must be made on the day of your eye examination. We will not alter chart notes at a later date to change which plan your exam is to be billed to.

**ROUTINE EXAM** - A routine exam, by definition, is an exam for people who have no eye disease or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contact lens) and any potential indicators of eye disease. If our doctor finds anything abnormal during your vision exam, further testing using your medical insurance will be needed.

Routine eye examinations through most Vision plans require prior authorizations. You must provide us with your Vision Plan policy information prior to services.

**MEDICAL EXAM** - Exam for evaluation of a medical-related complaint or follow-up of an existing medical condition. Examples that will necessitate your visit being submitted to your medical insurance include headache, eye irritation, dry eyes, floaters, glaucoma, cataract, double vision, macular degeneration, high risk medications, etc.

**Refraction** - A test that measures the eyes’ need for corrective lenses, and also assists in monitoring medical conditions of the eye. This test, however, will not provide sufficient information to write a prescription for contact lens, which requires a contact lens fitting.

Insurance companies separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. Typically, vision plans cover both the exam and the refraction, while medical policies cover only the exam. Medicare enforces the policy of requiring eye doctors to separately charge and collect for refractions. As many private insurance carriers adopt the policies of the federal government, many of our contracts with private insurance carriers now require us to separately collect for this non-covered service also.

We hope that this information will help you understand how your visit will be submitted to your insurance for today’s visit and future visits. If you are uncertain about your vision/medical benefits, please contact your insurance carrier.

---

Patient Signature/Responsible Party

Date



# EYE SPECIALISTS OF LOUISIANA

## Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used and disclosed to:

- Evaluate my health, diagnose my medical condition and provide treatment;
- Obtain payment from third-party payors;
- Conduct normal operations of our medical practice such as quality assessments, physician certifications, appointment and surgery scheduling;
- Fulfill other purposes which are listed in our Notice of Privacy Practices.

I have received a copy of Eye Specialists of Louisiana, L.L.C.'s Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information as well as certain rights that I have as a patient. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature or Representative's Signature

\_\_\_\_\_  
Relationship to Patient if signed by Personal Representative

---

### OFFICE USE ONLY

Patient's signature was not able to be obtained for the reasons documented below:

\_\_\_\_\_  
Date

Reason(s) Acknowledgment was not obtained: \_\_\_\_\_

Name of Staff Member: \_\_\_\_\_



# EYE SPECIALISTS OF LOUISIANA

## RESTRICTION REQUEST ON USES AND DISCLOSURES

You have a right to request restrictions on the uses and disclosures of your protected health information as described in the Notice of Privacy Practices. Eye Specialists of Louisiana, L.L.C. is not obligated to accept your proposed restrictions, but will give them consideration. Please describe any restriction requests that you would like to make in the section provided below.

I, \_\_\_\_\_ (print name) hereby request the following restrictions on the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. This is a complete list of my restriction requests. All previously signed expressions of my wishes concerning the use and disclosure of my personal health information for the purposes of treatment, payment or health care operations are null and void.

### RESTRICTIONS:

---

---

---

---

---

---

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### REVIEWER SECTION

The terms of this request are/are not (circle one) acceptable to **EYE SPECIALISTS OF LOUISIANA, L.L.C.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

**Comments:**

---

---